



acs CLINICAL CONGRESS

news

SAN FRANCISCO, CALIFORNIA

61ST ANNUAL CLINICAL CONGRESS OF
THE AMERICAN COLLEGE OF SURGEONS

WEDNESDAY, OCTOBER 15, 1975



FLANKED ON THREE SIDES by listeners, James V. Maloney, Jr., MD, FACS, presents the John H. Gibbon, Jr., Lecture Monday in the not-even-standing-room Larkin Hall. Registrants stood outside the doors to hear Dr. Maloney discuss "Pulmonary Problems in the Surgical Patient".

Role of body fluids subject of Ravdin science lecture

The I. S. Ravdin Lecture in the Basic Sciences will be delivered this afternoon by Arthur C. Guyton, MD, professor and chairman of the Department of Physiology and Biophysics, University of Mississippi, Jackson, Mississippi.

Dr. Guyton's topic is "The Role of the Body Fluids in Arterial Pressure and Cardiac Output Regulation".

The lecture will start at 1:30 in Larkin Hall of the Civic Auditorium.

In 1972, Dr. Guyton received the Wiggers Award of the American Physiological Society for cardiovascular research. He is a past recipient of the American Association for the Advancement of Science Gould Award for Cardiovascular Research. He

was selected as one of the ten outstanding young men of America by the United States Junior Chamber of Commerce in 1951.

Dr. Guyton was awarded a U.S. Presidential Citation in 1956 for his work in the development of aids for handicapped persons.

He is the author or co-author of some 307 publications, many of them dealing with cardiovascular physiology.

The I. S. Ravdin Lecture in the Basic Sciences was initiated in 1964 in honor of the distinguished Philadelphia surgeon, I. S. Ravdin, MD, FACS, who was actively involved in cancer research and treatment, and an early advocate of the use of chemotherapy for that disease.



FIRST IN LINE at Women's registration is Philip Sandblom from Lausanne, Switzerland. Actually, he's saving the place for his wife, and passes the time by making out his own schedule for the week. Dr. Sandblom is an Honorary Fellow of 25 years' standing.

Registration Facts

As of 5:00 pm Tuesday	
Doctors	11,729
Ladies	5,569
Exhibitors	1,929
Visitors	808
Press, staff & aids	197
TOTAL	20,232

Tapes can catch what you can't

Are you missing something? You don't have to.

ACS/Clinitapes will record virtually all of the general and specialty sessions, all major lectures and all 18 postgraduate courses during the Clinical Congress.

By ordering the tapes, you may audit sessions that you may have missed because of scheduling conflicts.

Sessions that will be recorded are identified in the official Clinical Congress program by a five or six-digit combination of letters and numbers within a cassette-shaped symbol.

A 16-page catalog containing a complete listing of *Clinitapes* from 1972 through the present Clinical Congress (including the 1973 Spring Meeting) is available at Booth 538 in Brooks Hall. The catalog also contains its own postage-paid order form.

Correlative clinic begins this morning

The Correlative Clinic, a Clinical Congress feature introduced the last time we met in SF, will be presented this morning when the first of two, one-hour cases (The Diagnosis and Management of a Retroperitoneal Mass) starts at 10:00. William P. Longmire, Jr., MD, FACS, will moderate.

The second case (Upper Gastrointestinal Bleeding) will follow, and be moderated by Marshall J. Orloff, MD, FACS.

The clinic is designed to demonstrate the importance of cooperation among the surgical specialties and between surgery and other medical disciplines. A 'team' from the University of California Medical Center, Los Angeles, will discuss Case I, and a team from the University of San Diego California, San Diego, School of Medicine, Case II.

Recertification is panel topic

Recertification and subcertification, a problem waiting in the wings for its cue to center stage (as soon as that 'other problem' stops hogging attention) will be explored this morning beginning at 10:30 in Larkin Hall, Civic Auditorium.

John M. Beal, MD, FACS, Chicago, will serve as moderator for a panel consisting of: Richard L. Varco, MD, FACS; Alfred S. Ketcham, MD, FACS; and William A. Larmon, MD, FACS.

Dr. Varco will discuss fragmentation in medicine: continuing proliferation in varieties of certificates of special competence. He will also discuss some of the merits of recertification about which he has some reservations, but he is quite opposed to further subcertification.

Dr. Larmon will, in essence, present the attitude of the American Board of Orthopaedic Surgery which has been against subcertification and is also against mandatory recertification. The board feels that continued competence should be encouraged through postgraduate study.

Dr. Ketcham, a surgical oncologist, favors greater recognition of his specialty area and is generally in favor of subcertification.

New Moderator

Victor M. Bernhard, MD, FACS, Milwaukee, will replace Edwin J. Wylie as moderator for the surgical forum session on Peripheral Vascular Surgery to be presented this morning at 8:30 in the Plaza Room of the Hilton Hotel.

Gaston urges:

'Trauma training needs upgrading'

Medical school curricula are "woefully inadequate" in the teaching of trauma to medical students and the nation's orthopaedic leadership assigns trauma a "low priority", according to Sawnie R. Gaston, MD, FACS, who presented the annual Scudder Oration on Trauma yesterday.

Dr. Gaston said that "Any hope of a significant lessening of the staggering toll of disability that follows in the wake of motor skeletal trauma today lies in the training of our young surgeons. The success of such training resides in the leadership of their teachers".

Dr. Gaston is former associate professor of clinical orthopaedic surgery at the College of Physicians and Surgeons, Columbia University, New York, and a noted specialist in fracture care.

Dr. Gaston reviewed the history of fracture services in this country, noting that until recent years there had been such a service in many of the nation's major hospitals. These services, he said, were based on the concept that all fractures constituted a surgical emergency.

In recent years, however, he said, these services have been phased out or downgraded, resulting not only in a loss to patient care but also in a loss of essential training possibilities for residents. Even more devastating, he said, was the fact that this situation had brought about "the attenuation of resident thinking about the relative importance of trauma to an orthopaedic surgeon and to his patients."

Dr. Gaston reported on a recent questionnaire he sent to the directors of 190 orthopaedic training programs to ascertain the status of teaching, training, and patient care after the patient arrives at a medical facility for definitive care, usually a hospital.

More than 40 percent of the institutions responded. They reported that 40 percent of their orthopaedic beds were occupied by fracture patients and that 37 percent of the orthopaedic cases operated each year were fracture cases. Yet only 29 percent of the hospitals had a fracture service (defined as having an attending as chief with residents rotating through the services; a separate out-patient clinic; attendings permanently assigned to supervise clinics, ward and operative cases; and a service chief resident on rotation or graduate fellow appointed for that specific service).

Dr. Gaston found an even more serious problem in the teaching of trauma care. The teaching of motor skeletal trauma was mandatory in only 19 percent of the programs in the survey, elective in 37 percent, and



DR. GASTON

both mandatory and elective in 44 percent. The latter meant that a short introductory course was given with the student then having the privilege of taking an elective in the subject if it appealed to him or her.

The average minimum number of hours of fracture teaching for each student over the entire medical school experience was eight hours for both the university and university-affiliated programs. The average maximum number of hours taught was 45 hours for university programs and 14 hours for university-affiliated programs.

"Today in our permissive society we permit students to elect whether or not they choose to learn something about a disease that kills 116,000 and injures 11,000,000 Americans every year . . .", Dr. Gaston said.

Dr. Gaston said that basic knowledge of trauma was essential to all physicians to develop the acumen to be aware of a patient's need and the judgment to make a wise referral for the skilled care of that need.

The Scudder Oration is named after Dr. Charles L. Scudder, who in 1917 established the first fracture clinic in the United States at the Massachusetts General Hospital.

Care Panel

Surgical Intensive Care will be the subject of the annual Pre- and Postoperative Care Panel Discussion to be presented this morning beginning at 8:30 in Civic Auditorium's Larkin Hall.

Gerald S. Moss, MD, FACS, will moderate a panel consisting of Josef E. Fisher, MD, FACS; Robert J. Lowe, MD; and Richard Virgilio, MD, CDR, MC USN.



SOCIETY OF PHILIPPINE SURGEONS in America held a business meeting and reception Monday. Officers of the group, from left, are Philip Chua, MD, Munster, Ind., who is editor of the quarterly publication "Philippine Surgeon"; Jacinto T. Rios, MD, FACS, Reseda, Calif., president-elect; **Hernan M. Reyes, MD, FACS, Chicago, president**; and I. D. Sunga, MD, FACS, Chicago, executive secretary. David B. Skinner, MD, FACS, from the University of Chicago, was guest speaker at the society's dinner Tuesday evening.

Protein boost may be cause of low resistance

A clue to the mystery of why resistance drops after an accidental injury, severe burn, or major surgery was reported yesterday by investigative teams from Boston University Medical Center and the University of California Medical Center, San Diego.

They reported identifying a small protein in the blood serum of traumatized patients that is present in ten times the normal amount.

"We believe that this normal protein, called immunoregulatory alpha globulin (IRA), is central to the regulation of part of the natural defense mechanism against infection", said Mark B. Constantian, MD, senior resident in surgery at the Boston University Medical Center.

"It may be that the observed susceptibility of traumatized patients to infection is due in part to derangement of a normal mechanism for controlling the immune response", he added.

Clinical and experimental evidence has shown over the last ten years that organisms relatively harmless to healthy individuals may be dangerous or even lethal to persons recently traumatized. Growth of tumors in experimental animals increases following trauma and surgeons have observed over the years that a patient who was thought to have been "cured" of cancer years before may suffer a recurrence of a tumor after undergoing an unrelated surgical procedure, such as a hernia repair.

The researchers drew blood serum samples from 101 patients before and after surgery or trauma. Control specimens were obtained from healthy medical school personnel. Twenty of 23 patients (87 percent) developed the inability to react normally to infection following major operation or accidental trauma. The serum prevented normal lymphocytes from functioning properly. The greater the trauma, the more likely the patient was to develop immunosuppressive serum. None of the 18 patients

who underwent relatively minor trauma, such as a reduction of a simple fracture, developed immunosuppressive serum. Twenty-five of 60 patients undergoing major surgery without complications developed the serum. Twenty-one of 23 patients undergoing major surgery with serious complications developed the serum.

After separating the serum proteins of many of these patients the investigators found excessive quantities of IRA.

Co-authors are James Manzoian, MD, chief resident in surgery, Boston University Medical Center; Jack C. Fisher, MD, FACS, head, Division of Plastic Surgery, University Hospitals, San Diego, Calif; and Richard B. Nimberg, PhD, assistant professor of biochemistry, Karl Schmid, PhD, professor of biochemistry, and John A. Mannick, MD, FACS, professor and chairman, Department of Surgery, all of Boston University Medical Center.

Lung Cancer

Survival time may be aided by TB vaccine

Survival may be prolonged in patients operated on for lung cancer by administering BCG, the tuberculosis vaccine, according to a report presented yesterday by Martin F. McKneally, MD, PhD, associate professor of thoracic surgery at Albany Medical College, Albany, New York. Dr. McKneally said the BCG apparently stimulates the defensive mechanism of the body.

The treatment was derived from the observation by Dr. McKneally that lung patients who developed infection in the membrane lining the chest cavity survived longer than patients who did not develop infection. Of 22 patients with pus in the pleural cavity, 11 were alive at 60 months compared to 94 who survived 60 months among 411 controls.

The BCG was given to hamsters, mice, and dogs to determine dosage and then to cancer patients. The BCG causes fever and weakness for several days in virtually all patients treated. "The survival fraction appears to be higher in those patients treated with intrapleural BCG, although the number of patients available for analysis of long-term results is small", said Dr. McKneally.

Procedure for rejoining digits is now feasible

It is now technically feasible to rejoin amputated fingers and toes using the modern operating microscope and suitable fine sutures and instruments, an Oakland, Calif., surgeon reported yesterday.

Required is a skilled replant team, including experienced operating room personnel and professionals who are committed, and a willingness by all members of the team to come to the emergency room at any time of the day or night, said Jack W. Tupper, MD, FACS, director of the Replant Team, Samuel Merritt Hospital, Oakland.

A decision must first be made as to whether the operation will be worthwhile, he said. There must be enough of the damaged finger left after surgery to make it useful. Crush injuries are much more difficult to restore than amputations caused by an axe, saw, or shears. If there are several finger injured, the first priority is given to the thumb.

Results are better if the patient is under 30, said Dr. Tupper.

The amputated finger should be put dry into a plastic bag, which is then sealed and placed in water with ice. A styrofoam picnic basket may be used to retard the melting of ice if a patient has to travel a long distance. The digit should not be packed in pure ice as it may freeze.

"For a variety of reasons, replantation may not be wise for a particular patient and judgment should be used in making a decision", said Dr. Tupper. "The replanted part must have the potential of being useful and there should be no undue risk to the general safety of the patient if these arduous procedures are to be embarked upon".

It is requested that smoking be limited to hallways and areas adjacent to scientific meeting rooms (where not prohibited by fire department regulations) and that no smoking occur in the meeting rooms before or during a presentation.



BENJAMIN F. BYRD, JR., right in photo at left, is retiring as chairman of the Commission on Cancer and received a plaque from Murray M. Copeland, a past chairman, in recognition of his achievements during his six-year tenure. The presentation was made Sunday evening at the Commission on Cancer dinner. Dr. Byrd will become president of the American Cancer Society. Also, at the same event, Mrs. John W. Cline of San Francisco, wife of the late Dr. Cline, who had served as chairman of the Commission, was presented with a bound copy of the Cancer Registry Manual which is dedicated to Dr. Cline. In addition, Will Webber, Registry consultant, presented Mrs. Cline with a bouquet of flowers from the staff members of the ACS Cancer Department.

Porous metal prosthesis aid to rebuilding bones

A prosthesis into which bone can grow has permitted healing of large gaps in long bones of experimental animals. This new technique offers the prospect of bridging segments of bones that have been destroyed by cancer or trauma in humans, according to a report presented yesterday.

The prosthesis is made of porous fiber metal that allows normal bone to grow into the space as the growth end of the bone continues to generate new tissue. The newly-growing bone becomes permanently attached to the fiber metal, which is compatible with living tissue.

Authors of the paper were Robert Alan Miller, MD, resident in orthopaedic surgery, Rush / Presbyterian - St. Luke's Medical Center, Chicago; Jorge O. Galante, MD, FACS, professor and chairman of the Department of Orthopaedic Surgery at Rush; and William Rostoker, PhD, Professor of Metallurgy, Department of Materials Engineering, University of Illinois at Chicago Circle.

The investigators described their first application of the prosthesis in 27 adult female baboons who were missing large segments equalling one-third the length of the entire bone. Two-thirds of them had bone graft chips placed around the prosthesis to stimulate new bone formation. The

animals were allowed to use their extremities immediately after recovery from anesthesia. All walked normally in less than seven days, but one developed a deep wound infection that required amputation.

The nine animals who did not receive bone chip grafts failed to form new bones of any consequence. But 14 of the 18 grafted animals completely reconstituted the missing segments after an average of four and a half months.

To date, nine grafted and five non-grafted animals have been studied. The prosthetic segments have been completely covered by normal-looking bone. The space in the prosthesis between wires was filled by healthy, living bone. The prosthesis provided rigid stability and no external support was required.

The porous titanium prosthesis will be tried in humans. "At the present time, the surgeon who is faced with a patient who requires removal of a considerable segment of a long bone must choose between amputation of the extremity and attempted reconstruction using cadaver bone or massive bone grafts", said Dr. Miller. "The disadvantages of amputation are obvious, and there are still many unsolved problems in the use of cadaver bone and massive bone grafts".

Tieing off better than packing for nose bleed

Surgery to tie off the bleeding artery is a safer and more reliable procedure than packing for continued or recurrent posterior nose bleed, two Chicago investigators reported Tuesday.

Anthony J. Geroulis, MD, resident, and William J. Powell, MD, FACS, associate professor of surgery, in the Ear, Nose and Throat Section at the Pritzker School of Medicine, the University of Chicago, reviewed treatment of 75 patients with posterior nose bleed seen between 1972 and 1974. Initial treatment in all cases was packing. This was kept in place for 48 to 120 hours. If the bleeding continued and could not be controlled by repacking and blood replacement, or if the patient developed labored breathing or became severely anxious because of the packing, surgery was carried out. Choice of anes-

thesia depended on the patient's physical status and ability to cooperate during the procedure.

Of the 75 patients surveyed, 44 were treated only by packing. Twenty percent had fever episodes from inflamed sinuses or ear inflammation. All experienced moderate to severe discomfort from the packs and required sedation. Two died of cardiorespiratory arrests.

The remaining 31 were all treated surgically, almost all by tying off the internal maxillary artery. There was no mortality and only one patient developed a postoperative complication of sinus inflammation. Hospitalization was shortened by half as compared to packing.

No relationship was found between high blood pressure and the occurrence of the bleeding or its severity.



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DOING THE HONORS—in pouring at the annual Welcoming Tea for wives is Mrs. H. William Scott, Jr., wife of incoming-President Dr. Scott. The get-acquainted event was held in the Grand Ballroom of the Fairmont. Dr. Scott will take office Thursday during the Convocation.

Harvard investigators issue warning on use of BCG

BCG, considered to be a helpful agent against cancer by stimulating the body's immune system against the disease, can stimulate cancer spread if given at the wrong time and injected in the wrong place, according to animal data presented yesterday by a group of Harvard University investigators.

Stephen T. Sonis, DMD, research fellow, Peter Bent Brigham Hospital, Harvard University; Peter Stelos, PhD, associate in surgery, Peter Bent Brigham Hospital, Harvard University; and Richard E. Wilson, MD, FACS, professor of surgery, Harvard Medical School, created a model that would stimulate a primary cancer in humans and studied how cells spread. Primary tumors were surgically removed from the hind legs of cancerous mice and, as a part of the immunotherapy treatment, live tumor cells were injected in the remaining hind limb either at the time of amputation or 24 hours later.

Some of the mice receiving tumor cells were given BCG, either intradermally or subcut-

aneously. Various combinations of treatments and sites of treatment were used.

The studies show that BCG, given intradermally and combined with injection of tumor cells, could be useful in limiting the spread of cancer to the lungs. When it was injected into the muscle, the spread of cancer to the lungs increased.

"The conclusions to be drawn from these investigations are that immunotherapy in inbred mice with chemically induced tumors can have an extremely beneficial effect on reducing pulmonary metastases after surgical excision of the primary tumors", the authors said. "Critical factors in these experiments were the timing of the immune therapy, the specific dose of live cells used and the route of BCG administration".

"Improper selection of these critical factors would result in an increase rather than a reduction in pulmonary metastases, underscoring the risks as well as the potential benefits of immunotherapy for malignant disease".

Breast Cancer

No longer one ideal operation

There is no longer one ideal operation for breast cancer, a New York cancer surgeon said yesterday.

"The individual patient should be treated on a selected basis in which the extent of the operative procedure is tailored to fit the extent of disease present in the particular patient", Jerome A. Urban, MD, FACS, told surgeons attending the first session of postgraduate course No. 10.

Dr. Urban, who is acting chief of the Breast Service at the Memorial Hospital for Cancer and Allied Diseases, said that the increased use of better cancer detection techniques, and the increased public awareness of the need for early diagnosis, means that breast cancer patients are now being seen at a much earlier stage than in previous years, and that they have a much better chance to be saved.

However, he said, great care must be taken in selecting the proper type of surgery for each patient. The recent emphasis on less radical mastectomy, he said, is not necessarily the best solution for every patient.

"The tremendous opportunity for improved salvage of this disease offered by detection of early lesions, which are more localized and with better prognosis, can be destroyed by over-emphasis and over-application of minimal surgical treatment", he said.

Dr. Urban recommended modified radical mastectomy for minimal breast cancers measuring under one cm in diameter and occurring in the upper outer quadrant of the breast with no spread to the axillary lymph nodes. He recommended radical mastectomy with removal of the axillary nodes for patients with larger infiltrating breast cancers occurring in the outer half of the breast and particularly those with suspicious axillary node findings. He reserves extended radical mastectomy in which the internal mammary chain of lymph nodes is also removed for patients with a high risk of spread of cancer to the internal mammary nodes, particularly those with clinically positive axillae with infiltrating breast cancers arising in the central and inner half of the breast.

With the combined approach of using different procedures for different stages of disease, Dr. Urban reports that his institution has attained ten year survival rates of 57 percent in 515 patients with infiltrating breast cancer with 44 percent axillary node involvement.

Caps and gowns for the Convocation ceremony tomorrow (Thursday) night can be picked up starting today at 8:30 am in the Civic Auditorium, Room 102; the room will close at 5:00 pm. Thursday's hours are 8:30 am until 3:00 pm.

Mass screening finds higher tumor incidence

The results of the first 18 months of a mass screening program for detection of breast disease reveal a much higher incidence of the disease than expected; a very high percentage of clinically occult tumors; and an unwillingness on the part of some physicians to perform a biopsy in the absence of clinical evidence of cancer.

This was reported yesterday in a paper read by Gordon F. Schwartz, MD, FACS, associate professor of surgery and director of clinical services, Breast Diagnostic Center (BDC) of the Jefferson Medical College, Philadelphia, Pa.

Dr. Schwartz reported on the center's experience in screening 13,907 patients between December, 1973, and June 30, 1975. The screening program is continuing. All patients are self-referred and without symptoms of breast disease. Screening consists of a combination of thermography, xeroradiography, and clinical examination.

Dr. Schwartz found an overall incidence of 7.6 cancers per thousand women screened. He said in an interview that this was higher than expected by a factor of about three. Of these patients, 45.3 percent had lesions that were clinically occult.

"... The high incidence of clinically occult lesions implies a (precise) method of screening and a high diagnostic accuracy within this program", Dr. Schwartz said. Among the clinically occult group of cancers only seven percent showed evidence of spread to the axillary lymph nodes and less than 23 percent of all patients in whom cancer was found showed spread to the lymph nodes. "Most (other) studies indicate that approximately 50 percent of breast carcinomas have at least one lymph node metastasis at the time of initial definitive treatment ...", Dr. Schwartz said.

Since it has been shown that ten-year survival rates are higher

when no lymph nodes or only one or two are affected, "it is a reasonable assumption that survival in those patients with clinically occult lesions should be excellent", Dr. Schwartz said. "In those patients with clinically occult lesions and negative lymph nodes, the survival should approach ninety percent, or even higher."

Despite this hopeful prognosis, Dr. Schwartz said that one group of 33 patients with occult tumors were advised against biopsy by their physicians despite positive findings noted by the BDC personnel at the time of the patient's visit. The physicians were unwilling to support recommendations for biopsy because they could not palpate "anything wrong" with the breast, "thereby completely ignoring radiographic evidence of disease. We therefore must direct educational efforts at physicians as well as at the lay public", Dr. Schwartz observed.

He said that part of the reluctance of physicians to biopsy nonpalpable lesions might be their unwillingness to remove large portions of normal breast in order to locate tiny areas of calcification or tumor which may or may not be cancerous. He recommended a technique that he described at the 1974 Clinical Congress involving needle localization and excision of these small areas of calcification or tumor using a circumareolar incision and specimen radiography. This would make possible a minimal incision with removal of the smallest possible volume of breast tissue.

Two techniques can reduce blood loss during surgery

Blood loss during surgery can be markedly reduced by deliberately lowering the blood pressure during the operation through a refinement of hypotensive anesthesia, and by retrieving, filtering, and returning to the patient during surgery, the blood lost at the operative site. This was reported yesterday by a group of investigators from the University of Arkansas Medical Center, Little Rock.

Seventeen patients have undergone total hip replacement operations using this combination of hypotensive anesthesia and intraoperative autotransfusion, said the investigators, Edward R. North, MD, resident, internal medicine; Carl L. Nelson, MD, FACS, professor and chairman of the Department of Orthopaedics; and Noel W. Lawson, MD, associate professor of anesthesiology. No complications were encountered and no donor blood was required.

The patients' religious beliefs had prohibited transfusion of donor blood. However, the

blood-saving technique is also receiving renewed interest because of the diminishing availability of donor blood and the complications associated with donor transfusion, said Dr. North.

Blood pressure was reduced by infusing the anti-hypertensive drug, sodium nitroprusside. The average blood pressure dropped 47 percent from pre-operative measurements.

"When compared to the expected blood loss using conventional anesthetic techniques, the net blood loss was reduced 76 percent in those patients with no previous hip surgery and 82 percent in those who had undergone previous hip surgery", said Dr. North, adding, "due to a reduction in blood loss, the operative field was drier, allowing greater ease of operative technique".

With the combined use of intraoperative transfusion, and refinements of hypotensive anesthesia, total hip replacement can be performed without homologous transfusion.



PRECISION INFUSION is the subject of the exhibit of Sigmamotor, Inc. at Brooks Hall. Roger Hungerford and Maurine Sevenski, Middletown, N.Y., set up the equipment which will maintain an accurate flow rate over a long period of time, making it especially useful for treatment of patients in intensive care units.

Getting it together



GETTING ACQUAINTED is the first item of business for 14 medical students from schools in California and neighboring states. For the third year, the Committee on Surgical Education in Medical Schools is sponsoring the program whereby medical students, selected by their schools, are invited to attend the Congress. The students met for breakfast Monday and will have lunch each day with a member of the committee. Seated far left is David E. Lindsey, representative of the AMA Medical Students Association. Medical students and their schools are (seated, from left) Marjorie Fine, UCLA; Merril Dayton, Utah; Robert Veith, Washington; Michael Holmes, Arizona; Randy Morris, Stanford; (standing), Committee members Thomas C. King, MD, FACS, and Frank G. Moody, MD, FACS; Curtis Sheldon, California-San Diego; Charles Heiser, Colorado; Leonard Reedyk, Alberta; Jack Taunton, British Columbia; Steven Gorenbein, California-Davis; James Killeen, Loma Linda; Richard Contro, California-Irvine; and Corrine Fligner, New Mexico. Missing from the photo is Fred Myers, California-San Francisco.

Ninety-two writers here to cover congress events

As of Tuesday afternoon, a total of 92 science writers and reporters representing newspapers and radio and television stations had registered in the Clinical Congress press room. The following media were represented:

Chicago Tribune; Toronto Star; San Francisco Chronicle; Milwaukee Journal; The Daily Californian; Associated Press; United Press International; San Francisco Examiner; Main Inchi (Japan); Oakland Tribune; National Inquirer; The Wall Street Journal; Medical World News; Oncology News; Surgical Congress News; Journal of the American Medical Association;

Point of View (Ethicon); Chirurgeon; Journal of the American Hospital Association; Contemporary Surgery; Journal of the AORN; Surgical Business; Consultant Magazine; Surgery Update; RN Magazine; International Medical News Service; Medical Products; Biomedical Technician; Selecta (Germany); People Magazine; Pacific Record; Honolulu Star Bulletin; Medical Economics; and Hospital Practice.

In addition, all of the television and radio network stations, and TV and radio local affiliates had registered in the pressroom.

Fellows, initiates may have formal color portraits taken in ACS robes

Initiates (or Fellows, for that matter) who wish to have a formal color portrait taken while wearing the College's robes, are reminded that Cristof Studios has set up a special studio in Brooks Hall (basement floor, directly opposite the elevators)

and a service booth in the exhibit area where appointments can be made today through Friday between 9:00 am and 5:00 pm. Although Cristof has an office in the Fairmont, photographs can only be taken in Brooks Hall.

MEETINGS... et cetera ... et cetera ... et cetera ... et cetera

University of Alabama
School of Medicine Alumni Assoc.
6:00 — 7:00 pm
Cocktail party
for alumni & friends
Hilton, Toyon Suite

Society of Air Force Clinical Surgeons
6:00 — 8:00 pm
Cocktail party
Marine Memorial Club
Regimental Room
609 Sutter Street

Akron City Hospital
5:00 — 7:00 pm
Annual Reception
Hilton, Freemont Suite

Albany Medical College Alumni
6:30 — 8:30 pm
Cocktail Party
Mark Hopkins, Golden Empire Room

Society for Surgery of the Alimentary Tract
12 noon — 2:00 pm
Board of Trustee's luncheon
Fairmont, Green Room

William A. Altemeier Society
7:00 — 10:00 pm
Annual dinner
St. Francis, Colonial Room

American University of Beirut Surgical Alumni
6:30 — 9:00 pm
Cocktail party
Fairmont, Empire room

Beth Israel of N.Y. Surgical Alumni
6:30—8:00 pm
Cocktail party
St. Francis, Kent Room

Committee of Canadian University Surgical Chairmen
3:00 — 5:00 pm
Meeting
Fairmont, Green Room

Christian Medical College, Vellore, India
6:00—8:00 pm
Dinner for alumni
Eighth Immortal Restaurant
Holiday Inn, 750 Kearny

Denton A. Cooley Surgical Society
6:00 — 9:00 pm
Cocktail party for
members & former trainees
of Dr. Cooley
Hilton, Plaza Room

Columbia P&S/Presbyterian Hospital Alumni
6:00 — 8:00 pm
Cocktail party
Fairmont, Pavilion Room

Central Surgical Association's Membership Advisory Committee
12 noon — 3:00 pm
Luncheon for M.A.C.
Fairmont, Vanderbilt Room

Cornell Medical College Alumni Assoc./New York Hospital Dept. of Surgery
5:30 — 8:00 pm
Reception
Fairmont, French Room

University of Chicago
5:30 — 7:00 pm
Cocktail party
Stanford Court, Gold Room

Dartmouth Medical School Affiliated Hospitals
6:00 — 8:00 pm
Cocktail party
Hilton, Rosewood Suite

Downstate Medical Center Alumni Association
6:00 — 8:00 pm
Cocktail party
Hilton, Continental Parlors 1 & 2
(for ticket, see L. Attarian,
Brooks Hall regis. area)

12th Evacuation Hospital (Vietnam)
8:00 pm
Reunion
Meet in lobby of
San Franciscan Hotel
(1231 Market Street)

Fifth (Harvard) Surgical Service Alumni
5:30
Dinner
Robert Mondavi Winery
(Buses leave from St.
Francis @ 5:30, & return)

Fourth Auxiliary Surgical Group
7:00 — 9:30 pm
Dinner
St. Francis, Yorkshire Room

French-Polyclinic Hospital of N.Y.
6:00 — 8:00 pm
Reception
Sheraton Palace, Suite of
Dr. John J. Jasaitis

Bowman Gray School of Medicine/ North Carolina Baptist Hospital Department of Surgery
5:30 — 7:30 pm
Cocktail party
Hilton, California Room

Hahnemann Medical College and Hospital
5:00 — 7:00 pm
Cocktail party for
alumni, faculty, & guests
St. Francis, Oxford Room

Henry N. Harkins Surgical Society
6:00 — 8:00 pm
Cocktail party for all surgeons
and surg. residents in state of
Washington)
Fairmont, California Room

University of Iowa Surgical Alumni
6:00 — 8:00 pm
Cocktail party
Fairmont, Cirque Room

Kansas University Medical Center Department of Surgery
7:00 — 9:00 pm
Cocktail party
Fairmont, Fountain Room

Society of Graduate Surgeons of LAC-USC Medical Center
6:00 — 8:00 pm
Cocktail party
St. Francis, Elizabethan C

Lehay Clinic Foundation
5:30 — 7:30 pm
Alumni Reception
Stanford Court, Blue Room
of India Suite

Maryland Chapter, ACS
6:30 — 8:30 pm
Cocktail party
St. Francis, Borgia Room

Marquette Medical College of Wisconsin Alumni
5:30 — 8:00 pm
Cocktail party
St. Francis, Georgian Room

University of Missouri Medical Alumni & Friends
6:30 — 8:00 pm
Cocktail party
Hilton, Vista Room (45th floor)

U.S. Navy
6:30 — 10:30 pm
Cocktail Party
Marine Memorial Club, Crystal
Ballroom, 609 Sutter

New Jersey Medical School
7:00 pm
Dinner
Mandarin Restaurant
900 North Point/Ghir. Sq.

New York Hospital
(see Cornell Medical College)

North Carolina Baptist Hospital
(see Bowman Gray School of
Medicine)

Presbyterian Hospital
(see Columbia P & S)

Roswell Park Surgical Society
12 noon — 1:30 pm
Luncheon
St. Francis, Olympic N & S

University of Pennsylvania Medical Alumni
5:30 — 7:30 pm
Cocktail party
Fairmont, Terrace Room

Peruvian American Medical Society (PAMS)
8:30 — 11:00 pm
Dinner
Empress of China Restaurant
838 Grant Avenue
(Call for res.: 434-1345)

Charles B. Puestow Surgical Society
7:00 — 9:00 pm
Cocktail party
Hilton, Continental Parlor III

Mount Sinai Medical Center of New York City
6:00 — 9:00 pm
Cocktail party for
surgical alumni
Hilton, Parlor 7

University of Utah College of Medicine, Div. of General Surgery
6:00 — 8:00 pm
Cocktail party
St. Francis, Elizabethan D

Vanderbilt Medical Alumni
6:30 — 8:00 pm
Reception
St. Francis, Olympic N & S

Vermont Chapter, ACS/University of Vermont College of Medicine
6:00 — 8:00 pm
Reception for alumni,
former residents, chapter
members, & members UVCM
Fairmont, Vanderbilt Room

Matthew Walker Surgical Club
7:00 pm
19th annual meeting
Fairmont, Grand Ballroom
Lounge (contact L. J. Ber-
nard @ Miyako Hotel)

Washington Hospital Center
6:00 — 8:00 pm
Cocktail party
Hilton, Parlor 8

Wayne State University School of Medicine
6:30 — 8:00 pm
Cocktail party
Mark Hopkins, Room of the Dons

Medical College of Wisconsin
(see Marquette)

THURSDAY

Society of University Surgeons Executive Council
7:00 — 8:30 am
Breakfast & meeting
St. Francis, Yorkshire Room
Surgery Dept.—Saginaw Coop
Hospitals
6:00—8:00 pm
Reception
St. Francis, Olympic North